Supreme Court, U.S.
FILED
OCT 29 1993
OFFICE OF THE CLERK

No. 93-510

IN THE
Supreme Court of the United States
OCTOBER TERM, 1993

AETNA LIFE INSURANCE COMPANY and
AETNA HEALTH MANAGEMENT,
Petitioners,

v.

STUART CIRCLE HOSPITAL CORPORATION,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

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MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF *AMICUS CURIAE* OF THE ASSOCIATION OF PRIVATE PENSION AND WELFARE BENEFIT PLANS IN SUPPORT OF PETITIONERS

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MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE*

The Association of Private Pension and Welfare Benefit Plans ("APPWP") respectfully moves this Court, pursuant to Rule 36.3, for leave to file the attached brief *amicus curiae* in support of the petition for certiorari in this case. The consent of attorney for the petitioner has been obtained. The consent of attorney for the respondent was requested but refused.

The APPWP is a non-profit organization founded in 1967 to protect and foster the growth of this Nation's private employer-sponsored employee benefit plan system. The members of the APPWP include both small and large employer sponsors (including approximately 90 Fortune 500 companies) of employee benefit plans, as well as numerous plan support organizations, such as consulting and actuarial firms, investment firms, banks, insurers and

other professional benefit organizations. Collectively, its more than 400 members sponsor or administer plans covering more than 100 million plan participants. This broad-based membership provides the APPWP with substantial expertise and experience in the entire spectrum of issues relating to all types of benefit plans and the APPWP has filed *amicus curiae* briefs in numerous cases involving important issues for the employee benefit plan community.

This case raises an extraordinarily important ERISA preemption issue for employer plan sponsors as they struggle with the continued escalation in medical costs that has threatened the viability of the voluntary, private sector employee health plan system. Faced with this escalation, plan sponsors increasingly have turned to a variety of cost containment techniques in an effort to avoid benefit decreases or plan terminations. The preferred provider organization ("PPO"), under which plans can offer health care to plan participants at a reduced cost through a select panel of medical providers, has become an important weapon in this war on costs.

The decision below, if allowed to stand, can only serve to remove this innovative and effective cost-containment technique from a plan sponsor's already limited arsenal. The PPO, at bottom, is a contractual arrangement between the PPO and a select group of medical providers, under which the latter agree to provide services and/or goods to the PPO's subscribers on a discounted basis. By requiring PPOs to include "any willing" medical provider in the panel, the Virginia statute at issue effectively "guts" the PPO concept as a cost-saving device. If participation in the provider panel cannot be limited, medical providers will have no incentive to offer meaningful discounts to plans for one plain fact—plans will be in no position to offer providers the increased patient volume that is the *quid pro quo* for the provider discount. The net effect of this state effort to regulate the makeup of PPOs will be the demise of the preferred provider concept as a cost-containment tool, to the ultimate detriment of

plan sponsors, plans themselves, and their millions of participants.

This type of costly state interference into employee benefit plan affairs is precisely what Congress sought to eliminate in including in ERISA itself an express preemption provision that is "conspicuous for its breadth." *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990). Nor is the Virginia statute "saved" from preemption as a law "which regulates insurance" as the Fourth Circuit erroneously concluded. The state law at issue does *not* address the "business of insurance," but rather, the contractual relationship between medical care providers and the party establishing the PPO which, in this ~~case, h~~happens to be an insurance carrier. There is nothing "insurance-unique" about the creation of a PPO; indeed, numerous non-insurance companies have established PPO networks and marketed them to employee benefit plans. Moreover, in a remarkably analogous context, this Court has held that an insurance company's creation of a pharmacy network which provided prescription drugs to policy holders at discounted rates did not constitute the "business of insurance." *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). Accordingly, the mere fact that the state law in question addresses PPOs established by insurance companies in no way takes it outside the scope of ERISA's broad preemptive sweep.

The APPWP submits that the decision below is wrong and, unless reversed, threatens the delicate balance struck by Congress between protecting participants' rights and confining plan costs in fashioning a federal scheme to govern this area. Virginia's efforts, if successful, can only encourage other states to intrude upon employee benefit plan administration and design matters under the guise of state insurance regulation. Indeed, as noted in the petition for certiorari, numerous other states already have adopted similar laws which, in a variety of fashions, limit

the exclusion of medical providers from PPO networks.* Given the medical care crisis that already exists, it is imperative that this Court act now to protect the employee benefit plan community from this type of costly state interference.

The APPWP therefore urges this Court to grant the petition for certiorari in this case and to accept the attached brief to assist the Court in its resolution of this matter.

Respectfully submitted,

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* *See* Petition for Certiorari at 10 n.2. *See* also BlueCross Blue Shield Association, *State Barriers to Managed Care: Results of a National Survey of Blue Cross and Blue Shield Plans* (2d ed. 1992), at 6-8.

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INTEREST OF *AMICUS CURIAE*

The interest of the *amicus curiae* is set forth in the motion accompanying this brief.

SUMMARY OF ARGUMENT

This case raises an extraordinarily important ERISA preemption question for employer plan sponsors already struggling with the continued escalation in health care costs. It is no secret that the continued rise in health care costs has placed enormous pressures on the Nation's private employee benefit plan system. Indeed, a recent General Accounting Office study indicates that in 1990

alone, American businesses spent 186 billion dollars in providing medical benefits to their employees.[1] The enormous cost of medical care threatens not only the continued existence of many employer-sponsored health plans, but also the economic competitiveness of many plan sponsors themselves.

Faced with expenditures of this magnitude, plan sponsors increasingly have turned to innovative cost-containment mechanisms in an effort to avoid massive benefit cuts or, in some cases, the termination of medical coverage entirely. The decision below, however, threatens the continued vitality of a major cost-saving option utilized by plan sponsors and plans today—the preferred provider organization ("PPO").

The PPO enables plans to offer participants access to a select group of medical providers who have agreed to provide their services on a discounted basis. The PPO's ability to contain or reduce a plan's medical expenditures is integrally tied to the PPO's ability to limit the number of preferred medical providers available to plan participants under the program. Only if the number of preferred providers is limited can a PPO offer the increased patient volume necessary to secure meaningful discounts from the providers. By upholding a state law requiring insurance company-sponsored PPOs to extend "preferred" status to "any willing" medical provider, the decision below effectively strips these PPOs of the ability to offer this essential *quid pro quo*. The inevitable result of this holding will be the demise of the PPO as a cost-saving mechanism, at least where sponsored by insurance companies, to the ultimate detriment of plan sponsors, plans themselves, and their participants.

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[1] U.S. General Accounting Office, *Employer-Based Health Insurance: High Costs, Wide Variation Threaten System* (GAO/HRD-92-125) (1992) (hereinafter "GAO Study"), at 3.

Not only is the decision below bad policy given the current crisis in medical care costs, it is bad law. While Congress' primary goal in enacting ERISA was the protection of participants' interests in their plans, it also recognized the voluntary nature of the employee benefit plan system. Accordingly, in crafting its comprehensive federal regulatory scheme for this area, Congress took steps to insure that employers would not respond "by decreasing benefits under existing plans or slowing the rate of formation of new plans." H.R. Rep. No. 807, 93d Cong., 2d Sess. 15 (1974). Among these steps was the elimination of the conflicting and costly maze of state regulation that had burdened plans in the past through an express preemption clause that this Court repeatedly has recognized as "conspicuous for its breadth."

The Fourth Circuit's conclusion that the state law in question is "saved" from ERISA preemption as a law "regulating insurance" is plainly wrong. The creation of a PPO simply is not transformed into the "business of insurance" whenever an insurance carrier engages in that activity. There is nothing "insurance unique" about the creation of a PPO network of providers; numerous non-insurers have created such networks and marketed them to employee benefit plans. Moreover, the inclusion of a particular provider in the PPO network in no way involves the relationship between the insurer and an insured; rather, it involves the contractual relationship between the provider and the PPO and the terms upon which the provider will make its services available. Not surprisingly then, in a closely analogous context, this Court has held that an insurance company's creation of a network of pharmacies which provided prescription drugs to insureds on a discounted basis did *not* constitute the business of insurance. *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). This Court's analysis in *Royal Drug* is controlling here and requires reversal of the decision below.

In sum, the delicate balance struck by Congress in ERISA between protecting participant rights and confining plan costs so as not to undermine the private employee benefit plan system requires preemption of the Virginia law here involved. This Court therefore should grant the petition and reverse the decision below.

ARGUMENT

1. The continued escalation in health care costs and the enormous burdens it has placed both on American businesses and the Nation's private employee benefit plan system are matters of public record. A recent General Accounting Office study indicates that in 1990 alone, American businesses spent approximately 186 billion dollars in providing health care benefits to their employees. GAO Study at 3. This same study pointed out the devastating impact these costs have on many American businesses:

> Rapidly increasing business outlays for group health insurance are a serious problem for all firms, but some firms have experienced severe hardships as their costs have escalated to levels that threaten the competitiveness of the firm. Firms in declining industries with aging work forces are faced with health insurance premiums that exacerbate their competitive problems. Such firms not only have to deal with the general rise in health care costs, but also are hit by further increases which reflect the poor health experience of their aging work force. Small firms are even more vulnerable since poor health experiences of one or two workers can threaten their capacity to obtain affordable health insurance coverage.

Id. at 12.

Faced with these dramatic costs, employer plan sponsors have few alternatives. Some firms, particularly small firms, have had little choice but to reduce benefits sig-

nificantly or eliminate coverage for their employees entirely. *Id.* at 12 n.16. Indeed, in 1990, nearly 50% of the Nation's uninsured were employed on either a full or part-time basis, while approximately an additional 33% of the uninsured were non-working dependents of such employees. *Id.* at 23. Such actions only heighten the problems faced by those employers who have continued to provide medical benefits to their employees since generally "health costs associated with uninsured or underinsured small firm employees are passed on to larger firms." *Id.* at 12 n.16.

Other firms have responded to the crisis through a variety of innovative cost-containment and savings measures largely designed to permit them to continue providing meaningful coverage to their employees. Managed care programs, such as PPOs and Health Maintenance Organizations ("HMOs") which impose limitations on a participant's choice of provider, have proven to be popular and cost-effective alternatives for plan sponsors in their efforts to combat medical costs. A recent study indicates that in 1991, a majority of Americans with health coverage were enrolled in such managed care-type programs.[2] Moreover, during 1991 alone, PPOs and similar point of service plans increased their market share by over 40%.[3]

A PPO is able to reduce plan costs by extending plan participants access to a select panel or network of medical providers who have agreed to provide medical services on a discounted or other non-traditional fee-for-service basis. A PPO's ability to offer such savings to plans and plan sponsors in large part is dependent on the PPO's ability

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[2] KPMG Peat Marwick, *Health Benefits in 1992, in Benefits Spectrum* (Oct. 1992), at 2.

[3] *Id.* (indicating that the market share of such plans increased from 24% to 34% in 1991).

to limit the number of providers who are "preferred" or included within the network. This is because the PPO can offer providers the increased patient volume that is the essential *quid pro quo* for the negotiated discount arrangements only if the number of providers is limited. "Any willing provider" statutes such as that upheld by the court below effectively "gut" the preferred provider concept by eliminating the PPO's bargaining power in this key area. Not surprisingly then, a recent study estimated that such laws would reduce a plan's savings on benefit claims anywhere from 8% to over 14%.[4]

Nor are the lost savings limited to benefit claims. Such legislation also increases the PPO's costs both in establishing and administering the provider network. For example, if it must deal with all providers, rather than a select few, the PPO will incur increased expenses in credentialing providers, negotiating, executing, and administering provider agreements, and monitoring provider performance.[5] The same study which found a reduction in benefit savings estimated that "any willing provider" legislation increases a PPO's administrative costs anywhere from 34% to 52%.[6] These additional costs obviously would be passed on to plans, thereby further undermining the PPO's effectiveness as a cost-containment measure.

The net losers if such state legislation is upheld obviously will be plan sponsors, their plans, and ultimately plan participants themselves, all of whom will be deprived

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[4] The Wyatt Co., *Report to Health Insurance Association of America: Cost Analysis of State Legislative Mandates on Six Managed Health Care Practices* (1991), at 19-20 (hereinafter "Wyatt Study"). *See also* BlueCross BlueShield Association, *State Barriers to Managed Care: Results of a National Survey of Blue Cross and Blue Shield Plans* (2d ed. 1992), at 5 (hereinafter "BlueCross Study").

[5] BlueCross Study at 6.

[6] Wyatt Study at 15-16.

of a significant cost-saving opportunity at the very time that medical cost escalation has threatened the viability of the voluntary, private sector employee benefit plan system. Nor is this potential harm mitigated by the fact that Virginia statute addresses only insurance company-sponsored PPOs. If the creation of a PPO is viewed as the "business of insurance" subject to permissible state regulation, state efforts to regulate the makeup of PPOs established by non-insurance companies can be anticipated.[7] Moreover, even if such laws are limited to insurance company-sponsored PPOs, the elimination of insurers from the PPO market will have a negative impact on the availability of PPO-type arrangements to many plans, and small plans in particular. Unlike insurance carriers, many plans simply do not possess "enough negotiating power in geographic health care markets" to "obtain[] discounted fees with providers."[8] Thus, if allowed to stand, the decision will greatly undermine, if not eliminate, the PPO as a meaningful cost-saving alternative.

2. The decision below is consistent with ERISA's purposes and incompatible with its broad preemption of state law. While Congress' "primary goal" in enacting ERISA was the protection of the interests of plan participants, it also was keenly aware of the voluntary nature of our employee benefit plan system and "the public interest in encouraging the formation of employee benefit plans."

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[7] For example, in *General Motors Corp. v. California State Bd. of Equalization*, 815 F.2d 1305 (9th Cir. 1987), *cert. denied*, 485 U.S. 941 (1988), a state insurance "premium tax" calculated by reference to benefits paid by plans which had purchased "excess-risk" insurance and passed on by insurers to such plans was upheld against preemption challenge as a law regulating insurance. This ruling undoubtedly encouraged state efforts to impose a similar tax on plan administrators. *See E-Systems, Inc. v. Pogue*, 929 F.2d 1100 (5th Cir.), *cert. denied*, 112 S. Ct. 585 (1991) (finding such law preempted by ERISA).

[8] GAO Study at 24.

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987). Indeed, ERISA's legislative history makes clear that Congress was concerned not to burden plans so heavily by ERISA's requirements that "employers respond . . . by decreasing benefits under existing plans or slowing the rate of formation of new plans." H.R. Rep. No. 807 at 15.

Not only did Congress seek to minimize the regulatory burdens imposed by ERISA itself, it also relieved plan sponsors and plans from the costly, conflicting and inefficient maze of state regulation that had plagued them in the past. It did so through the inclusion of an express preemption provision—ERISA § 514(a), 29 U.S.C. § 1144(a)—which is "conspicuous for its breadth" and "establishes as an area of exclusive federal concern the subject of every state law that 'relate[s] to' an employee benefit plan governed by ERISA." *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990). The reason for its inclusion is clear:

> ERISA's pre-emption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patchwork scheme of [state] regulation would introduce considerable inefficiencies in benefit program operation, *which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them.*

Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 11 (1987) (emphasis added).

The court below correctly determined that the Virginia statute here involved "relates to" employee benefit plans, and thus falls squarely within the scope of ERISA's preemption provision. Indeed, this relationship is beyond dispute since the primary market for PPOs is employee benefit plans and any state regulation of the PPO's makeup

directly impacts a plan's benefit structure, administration and costs. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) (state mandated benefit law requiring inclusion of minimum mental health coverage in group health insurance policies "relates to" employee benefit plans within meaning of ERISA's preemption provisions).

However, the court's ultimate conclusion that this statute was "saved" from preemption under ERISA § 514 (b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), as a law "regulating insurance" constitutes plain and dangerous error. This court's prior teachings demonstrate that this savings clause was not intended to allow state regulation of all aspects of an insurance company's plan-related activities. *See Pilot Life Ins. Co. v. Dedeaux, supra; Metropolitan Life Ins. Co. v. Massachusetts, supra.* Rather, like the similarly worded McCarran-Ferguson Act, the savings clause "appears to have been designed to preserve the . . . reservation of the *business of insurance* to the States." *Metropolitan Life*, 471 U.S. at 744 n.21 (emphasis added). Thus, only state laws which regulate the "business of insurance," as opposed to the business of insurance companies, properly can fall within its ambit. And, indeed, the lower courts have held that an insurance company's plan-related activities are outside the saving clause's scope where they do not constitute the "business of insurance." *See, e.g., Powell v. Chesapeake & Potomac Tel. Co.*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986) (insurance company's provision of administrative services to plan is not the business of insurance); *Insurance Bd. v. Muir*, 819 F.2d 408 (3d Cir. 1987) (to same effect as *Powell*).

The decision below blurs and confuses this basic distinction between the "business of insurance" which is within the savings clause, and the "business of insurance companies," which is without. As a threshold matter, the

business activity here at issue does not even qualify as the "business of insurance companies." While insurance companies have become increasingly active in establishing PPO networks and marketing them to plans on both an insured and self-funded basis, there is nothing insurance company "unique" or "specific" about the creation and administration of a PPO network of medical providers. Many PPOs in operation today are sponsored, developed and promoted by groups of medical providers themselves or by HMOs.[9] In addition to this "provider sponsored plan" model, others are developed by third party entrepreneurs who are neither providers or insurance carriers.[10] These "broker model" plans incur the expenses associated with establishing a network of providers, *e.g.*, soliciting and negotiating contracts with multiple providers and administering the program, and "sell access to these networks to insurance companies and self insured employers."[11] Thus, the creation and administration of a PPO is not even the "business of insurance companies," but rather, a business activity engaged in by insurance companies and many other non-insurers.

More importantly, the activity regulated by the Virginia statute does not constitute the "business of insurance" under any proper definition of that term. The precise activity regulated by the Virginia statute—a PPO's inclusion or exclusion of medical providers—simply does not involve the "relationship between insurer and insured" which this Court has recognized repeatedly as the "focus" of the business of insurance. *E.g.*, *SEC v. National Sec., Inc.*, 393 U.S. 453, 460 (1969). Nor does it involve the underwriting or spreading of a policyholder's

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[9] National Health Lawyers Association, *The Insider's Guide to Managed Care: A Legal and Operational Roadmap* (1990), at 20-21, 53.

[10] *Id.*

[11] *Id.* at 21.

risk which is an "indispensable characte[illegible] of insurance." *Royal Drug*, 440 U.S. at 212.

Rather, the statute is directed at the contractual relationship between the PPO and medical providers and the terms upon which those providers will make their services available under the PPO program. While this contractual relationship impacts an insurer's costs in meeting its obligations under any contract of insurance it might offer allowing access to its PPO, the PPO-provider relationship is entirely separate and distinct from that between the insurer and the insured and any underlying policy of insurance. Indeed, the best evidence that the contractual relationship between a PPO and its medical providers does not constitue the "business of insurance" is that such relationship is part and parcel of *every* PPO, including those established by *non*-insurers and those which provide access to plans on a *non*-insured, fee-for-service basis.[12] If this relationship is not the "business of insurance" in these latter situations—and it is not—there is no reasoned basis for concluding that it becomes such whenever a PPO is sponsored by an insurance company and made available to employee benefit plans on an insured basis.

Not surprisingly then, in a remarkably analogous context, this Court already has concluded that an insurance carrier's contractual relationship with a provider of goods and services to its policyholders is not the "business of insurance." In *Group Life & Health Ins. Co. v. Royal Drug Co., supra*, an insurance carrier entered into agreements with pharmacies, under which the pharmacies agreed to provide prescription drugs to policyholders on a discounted basis. In holding that this insurer-created pharmacy "network" did not constitute the business of

[12] Of course, even insurance company-sponsored PPOs, including the petitioner in this case, offer their services to plans on a non-insured basis, *i.e.*, self-funded plans pay a fee for access to the network. See District Court Op., Petition at 15a.

insurance, the Court emphasized two facts. First, the participating pharmacy agreements were "*not* 'between insurer and insured' ", but rather, were "separate contractual arrangements between [the insurer] and pharmacies engaged in the sale and distribution of goods and services other than insurance." 440 U.S. at 216. Second, the agreements did not involve the underwriting of risk, but the terms upon which the insurer would pay for goods and services in meeting its contractual commitments to policyholders. As the Court explained:

> The fallacy of petitioners' position is that they confuse the obligations of Blue Shield under its insurance policies, which insure against the risk that policyholders will be unable to pay for prescription drugs during the period of coverage, and the agreements between Blue Shield and the participating pharmacies, which serve only to minimize the costs Blue Shield incurs in fulfilling its underwriting obligations.

Id. at 213. This same analysis applies here and requires reversal of the decision below.[13]

In short, Virginia's attempt to impose an "any willing provider" requirement on insurance company-sponsored

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[13] Nor can the *Royal Drug* decision be distinguished on the ground suggested by the court below—that participation in the pharmacy network is available to "any pharmacy which agreed to the insurance company's terms." Fourth Circuit Op., Petition at 12a. This feature played *no* part in this Court's conclusion that the activity there involved did not constitute the business of insurance. Indeed, this Court made clear that the insurer's contractual relationship with pharmacies would not constitute the business of insurance even if it had chosen to deal with a single vendor through the following example:

> Suppose, for example, that an insurance company entered into a contract with a large retail drug chain whereby its policyholders could obtain drugs under their policies only from stores operated by this chain.

Royal Drug, 440 U.S. at 215. Thus, an insurer's ability to exclude providers from a PPO is totally irrelevant to the "business of insurance" equation.

PPOs does not regulate the "business of insurance," and thus falls outside the scope of the insurance savings clause. This Court therefore should give full effect to ERISA's broad preemption provision to relieve plans and plan sponsors from this form of costly and inefficient state interference. Moreover, this Court should do so now so as to assure the employee benefit plan community that it will not be deprived of this increasingly important weapon in combating the current crisis in medical care costs.

CONCLUSION

For the reasons stated above, this Court should grant the petition for certiorari and reverse the decision below.

Respectfully submitted,

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